

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155235		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 05/19/2011	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 200 26TH STREET LOGANSPORT, IN46947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: May 16, 17, 18, 19, 2011.</p> <p>Facility number: 000140 Provider number: 155235 AIM number: 100266960</p> <p>Survey team: Tim Long, RN, TC Rick Blain, RN (May 16. 17, 2011) Angie Strass, RN Julie Wagoner, RN</p> <p>Census bed type: SNF/NF: 96 SNF: 19 Total: 115</p> <p>Census payor type: Medicare: 14 Medicaid: 78 Other: 23 Total: 115</p> <p>Sample: 23</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0225 SS=D	<p>Quality review completed on May 24, 2011 by Bev Faulkner, RN</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility staff failed to notify the Administrator of a Resident to Resident</p>			F0225	<p>F225</p> <p>It is the policy of Miller's</p>		06/18/2011

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	<p>altercation (Resident's #21, 41) for 1 of 2 allegations of abuse reviewed.</p> <p>Findings include:</p> <p>On 05/19/11 at 1:45 P.M., an allegation of abuse involving two residents (Residents #41 and 21) was reviewed. The report indicated on 04/23/11, Resident #21 was blocking a doorway and kicked and hit Resident #41 who retaliated and hit Resident #21. Two nursing assistants were in the room, separated the residents, and reported the incident to the charge nurse. However, the charge nurse did not follow the facility abuse policy and the Administrator was not made aware of the incident until 04/25/11. The Social Services Director, who had been conversing with Resident #41, was made aware of the incident, on 04/25/11, and she then reported the incident to the Administrator. The Administrator then followed the facility's Abuse policy and procedure and initiated an investigation and reported the allegation of abuse to the Department of Health and other agencies.</p> <p>Interview with the Administrator, on 05/19/11 at 2:00 P.M., indicated he was not made aware of the incident timely and thus could not ensure timely reporting. He indicated the staff involved were counseled regarding their delay in</p>				<p>Merry Manor to report all abuse allegations to the Administrator or designated representative immediately and to other officials in accordance with State law (including to the State survey and certification agency).</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>All staff will be in serviced on June 7th on our Abuse Investigation Worksheet (Attachment A), Abuse Prohibition, Reporting, and Investigation (Attachment B), Resident Abuse (Attachment C), and Resident to Resident Abuse (Attachment D). All staff will then receive mandatory monthly in services regarding reporting abuse, online through our Silverchair training program for the next 3 months and then quarterly thereafter to ensure compliance.</p> <p>Findings will be corrected upon discovery and a summary will be provided at the Monthly QA Committee meeting.</p> <p>All corrections will be completed by June 18, 2011.</p>		

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F0226 SS=D	<p>reporting the incident to the Administrator.</p> <p>3.1-28(c)(d)(e)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure staff followed the facility abuse policy and procedure regarding notifying the Administrator of a Resident to Resident altercation (Resident's #21, 41) for 1 of 2 allegations of abuse reviewed.</p> <p>Findings include:</p> <p>On 05/19/11 at 1:45 P.M., an allegation of abuse involving two residents (Residents #41 and 21) was reviewed. The report indicated on 04/23/11, Resident #21 was blocking a doorway and kicked and hit Resident #41 who retaliated and hit Resident #21. Two nursing assistants were in the room, separated the residents, and reported the incident to the charge nurse. However, the charge nurse did not follow the facility abuse policy and the Administrator was not made aware of the incident until 04/25/11. The Social</p>			F0226	<p>F226</p> <p>It is the policy of Miller's Merry Manor to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of resident's and the misappropriation of resident property.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>All staff will be in serviced on June 7th on our Abuse Investigation Worksheet (Attachment A), Abuse Prohibition, Reporting, and Investigation (Attachment B), Resident Abuse (Attachment C), and Resident to Resident Abuse (Attachment D). All staff will then receive mandatory monthly in services regarding reporting abuse, online through our Silverchair training program for the next 3 months and then quarterly thereafter</p>		06/18/2011

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	<p>Services Director, who had been conversing with Resident #41, was made aware of the incident, on 04/25/11, and she then reported the incident to the Administrator. The Administrator then followed the facility's Abuse policy and procedure and initiated an investigation and reported the allegation of abuse to the Department of Health and other agencies.</p> <p>The facility's policy and procedure, of 05/07/10 and indicated as current, included the following instructions: "...9. All reports of abuse must be reported to the Administrator immediately, and to the resident's representative, within 24 hours of the reporting or discovery of the incident...."</p> <p>Interview with the Administrator, on 05/19/11 at 2:00 P.M., indicated he was not made aware of the incident timely and thus could not ensure timely reporting. He indicated the staff involved were counseled regarding their delay in reporting the incident to the Administrator.</p> <p>3.1-28(a)</p>				<p>to ensure compliance.</p> <p>Findings will be corrected upon discovery and a summary will be provided at the Monthly QA Committee meeting.</p> <p>All corrections will be completed by June 18, 2011.</p>		

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 4 of</p>			F0441	F 441 It is the policy of Miller's		06/18/2011

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	<p>4 licensed nurses (LPN #2 and RNs #3, 4, and 5) observed obtaining blood glucose levels followed instructions for proper sanitation of the glucometers. This deficient practice affected of 7 of 7 residents reviewed for infection control in a sample of 23. (Residents #34, 27, 105, 108, 32, 15, and 4)</p> <p>Finding includes:</p> <p>During observation of the medication administration pass, conducted on 05/17/11 at 4:15 P.M., RN #4 was noted to have checked the blood sugar level with a facility glucometer for Resident #34. After RN #4 had disposed of the lancet and test strip, the nurse placed the glucometer into the plastic basket full of unused lancets and went back into the hall, from the resident's room, and placed the basket on top of the medication cart. She then proceeded to wipe the glucometer with a germicidal disinfectant wipe. The wiping process took less than 30 seconds. The glucometer was then left to air dry.</p> <p>The procedure was repeated by RN #4 for Resident #27 utilizing a different glucometer she obtained from a plastic bag in the medication cart.</p> <p>LPN #2 was observed, on 05/17/11 at</p>				<p>Merry Manor to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>All Nursing staff will be in serviced on June 7th and will sign our new Cleaning of the Glucometer Policy (Attachment E), which complies with the manufacturer's guidelines of our disinfectant wipes (Attachment F). The DON or Designee will make daily rounds for 4 weeks, then weekly for 4 weeks, then monthly for 4 months checking to ensure proper protocol is being followed.</p> <p>Findings will be corrected upon discovery and a summary will be provided at the monthly QA Committee meeting.</p> <p>All corrections will be completed by June 18, 2011.</p>		

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	<p>4:30 P.M., obtaining blood sugar levels for Resident #15 and #4. The nurse was noted to clean the glucometer with a germicidal wipe. The cleaning process took less than 30 seconds. The nurse then indicated the glucometer needed to air dry for approximately 5 minutes. After she had obtained the blood sugar for Resident #15, LPN #2 then again wiped the glucometer off with the germicidal wipe. Again the wiping procedure took less than 30 seconds. After approximately 4 minutes, the glucometer was noted to be totally dry to touch and no visible dampness was noted. After 5 minutes, LPN #2 then proceeded to utilize the glucometer to check the blood sugar level for Resident #4.</p> <p>An interview with LPN #2 on 5/17/11 at 4:40 P.M., indicated the unit she did the blood glucose checks on had 2 glucometers which were not assigned to individual residents.</p> <p>LPN #5 was observed on 5/17/11 at 11:00 A.M., obtaining blood sugar levels for Resident's #32 and #108. LPN did not clean the glucometer used to check Resident #32's blood sugar before or after the procedure. LPN #5 used a different glucometer to check Resident #108's blood sugar and did not clean the glucometer before or after the procedure.</p>						

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	<p>RN #3 was observed on 5/17/11 at 11:30 A.M., obtaining a blood sugar for Resident #105. The nurse did not clean the glucometer before or after the procedure.</p> <p>On 05/19/11, 1:30 P.M., observation of the cleaning procedure for a glucometer was observed by unit manager, RN #6 and the Director of Nursing (DN). RN #6 utilized the germicidal wipe to clean all surfaces of the glucometer. The wiping procedure took less than 30 seconds. The drying procedure was then timed and the glucometer appeared to be totally dry with no visible or touchable wetness. The germicidal wipe, utilized to clean the glucometer was noted to be dry to touch after approximately 2 minutes.</p> <p>An interview with the DN on 5/19/11 at 1:40 P.M., indicated the facility did not have individual glucometers for all residents.</p> <p>Review of the facility's policy and procedure, titled, "Cleaning of Glucometer" indicated the following: "...D. Follow manufacturer's instructions related to length of time to disinfect before reusing."</p> <p>Review of the manufacturer's directions</p>						

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	for disinfecting included the following: "Thoroughly wet pre-cleaned, hard, non-porous surfaces with a wipe, keep wet for 5 minutes, and allow to air dry...." 3.1-18(b)(2)						